EMPLOYEE LEAVE APPLICATION

PROCESS/INSTRUCTIONS:

1. Employee completes the application prior to the leave, when reasonably possible.
2. Employee obtains signature of supervisor.
3. Submit form to Human Resources.
4. Human Resources will review and send Healthcare Provider certification.
5. Healthcare Provider Certification must be completed by physician and faxed to HR for Leave Approval.

EMPLOYEE	TITLE	DATE OF REQUEST
DEPARTMENT	SUPERVISOR	HIRE DATE

ADDRESS *(Street, City, State, Zip Code)*	HOME PHONE NUMBER/WORK EXT
TREATING PHYSICIAN *(First and Last Name)*	PHYSICIAN'S PHONE

LEAVE START DATE	RETURN-TO-WORK DATE	☐ This Is an intermittent leave request. Frequency:	☐ This leave request is Workers Compensation related.

REASON FOR TIME OFF:

☐ The birth of my child, or the placement of a child with me for adoption or foster care. DUE DATE:_____

☐ To care for a sick child for treatment and/or supervision.

☐ A serious health condition that makes me unable to perform the essential functions of my job.

☐ A serious health condition for which I am needed to provide care for my:
☐ Parent ☐ Parent-in-Law ☐ Spouse ☐ Grandparent ☐ Domestic partner ☐ Domestic partner's child

☐ Leave for victims of Domestic Violence; or family member to assist:
☐ child, ☐ spouse, ☐ parent, ☐ parent in-law, ☐ grandparent ☐ person dating employee

☐ Qualifying (Military) Exigency Leave for:
☐ Short –notice deployment ☐ Military events and related activities ☐ Childcare and school activities
☐ Financial and legal arrangements ☐ Counseling ☐ Rest and recuperation ☐ Post deployment activities

☐ I am a ☐ spouse ☐ child ☐ parent ☐ next of kin to a covered service member with a serious injury or illness.

EMPLOYEE AGREEMENT FOR LEAVE

I understand that I need to give as much notice as possible when requesting leave so my supervisor can provide appropriate coverage while I am away on leave. If this leave is approved, I understand the following:

- *I may be required to provide a Return to Work Medical Evaluation prior to my return to work.*
- *I declare that the information provided by me on this form is true and correct.*

EMPLOYEE SIGNATURE *(I have read the above)*	DATE	SUPERVISOR SIGNATURE	DATE

HUMAN RESOURCES REVIEW/APPROVAL

ELIGIBLE FOR FMLA LEAVE?	USED FMLA IN PAST?	ELIGIBLE FOR WA FAMILY CARE (FCA) LEAVE?
☐ Yes ☐ No – Why:	☐ No ☐ Yes – When:	☐ Yes ☐ No – Why:

AMOUNT OF PAID LEAVE AVAILABLE	AMOUNT OF UNPAID LEAVE	TYPE OF LEAVE THAT WILL BE TAKEN
_____Sick _____ Vacation _____ Personal Holiday	_____	

COMMENTS

HUMAN RESOURCES APPROVAL ☐ Approved ☐ Denied - Why:	HR Director or Designee	DATE

Revised June 2018

For additional policy information on Leave, see the HR Policies and Procedures Manual, Section 10.17